LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
CLINICAL EVENT NOTIFICATION/MANAGERIAL REVIEW

In order to prevent discoverability, *keep only one copy of this report and any attachment(s) in an Administrative File. Do not save them on a computer, e-mail them, include or reference them or discussions with Clinical Risk Management in the client's record.*

1. **Client Last Name:**	2. **Client First Name:**	3. **DOB:**	4. **Age:**	5. **Gender:**	6. **IS#:**	7. **Event Date:**

8. **Service Area:**	9. **Provider #:**	10. **Special Program (e.g., FSP/AB 109):**	11. **Provider Name/Address:**	12. **Event Location:**

13. **M.D./D.O./N.P.:**	14. **Psych. Diagnoses:**	15. **List frequency/dosages of current psychotropic medications:**

16. **Current Medical Problem(s)? Y ☐ N ☐**

Note:
The response to **Item 17** will determine if the medication regimen in **Item 15** is within DMH Parameters for Medications
An "**N**" response to **Item 17 A - C** requires the completion of **Item 25** on **Page 2**.

17. **Is the regimen in Item 15 within DMH Parameters? Y ☐ N ☐** If **N**, check applicable boxes **A - C** below and submit **Page 2**.

☐ A. Use of Two or More Anti-psychotics	☐ B. Use of Two or More New Generation Antidepressants	☐ C. Use of a Benzodiazepine in a Client with a Co-Occurring Substance Use Disorder

18. **Select Clinical Event Category: Submit Page 2 of the report for (*) asterisked categories within 30 days.**
Submit Page 2 and 3 of the report for (**) asterisked categories within 30 days.

1. ☐ Death - Other than Suspected/Known Medical Cause	*5. ☐ Client Self-Injury Requiring EMT (Not Suicide Attempt)	*10. ☐ Threat of Legal Action
2. ☐ Death - Suspected/Known Medical Cause	*6. ☐ Client Injured Another Person Who Required EMT	*11. ☐ Client Assault by Another Client Requiring EMT
**3. ☐ Death - Suspected/Known Suicide	**7. ☐ Suspected/Alleged Homicide by Client	*12. ☐ Adverse Drug Reaction Requiring EMT
**4. ☐ Suspected/Known Suicide Attempt Requiring Emergency Medical Treatment (EMT)	*8. ☐ Medication Error	*13. ☐ Alleged Client Assault by Staff
	*9. ☐ Suspected/Alleged Inappropriate Alleged Interpersonal Relationship	*14. ☐ Inaccurate/Absent Laboratory Data Resulting in a Client Requiring EMT

19. **Describe the Event: Includes important facts. If needed, use additional sheet(s) that includes a statement of confidentiality (the last sentence at the bottom of this page). Attach other available, relevant information, e.g., articles, post event team review.**

20. **Reporting Staff Name:**	21. **Manager Name:**	22. **Manager's Signature:**	23. **Manager's Phone:**	24. **Report Date:**

Mail **Page 1** within two (2) business days of the event to the attention of Roderick Shaner, M.D., Medical Director, Los Angeles County Department of Mental Health, 550 S. Vermont Ave., 12th Fl., Los Angeles 90020.

Complete/mail **Page 2** for (*) asterisked events **and** for any report with an "**N**" to **Item 17**, **or Page 2** and **3** for (**) asterisked events within 30 days to the attention of Mary Ann O'Donnell or Doris Benosa.

Contact Clinical Risk Management staff for questions at 213-637-4588, 213-639-6326, or 213-351-5095.

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Client Last Name:	Client First Name:	IS #:	Manager Name:	Event Date:	Manager Report Date:

25. **If Item 17 on Page 1 is "N", does the clinical record contain documentation of:**

A. The risks/benefits for use of the medication(s)? **Y** ☐ **N** ☐ and, if applicable

B. A consultation with furnishing supervisor if the medications were furnished by an N.P.? **Y** ☐ **N** ☐

Note: If either **A** or **B** is "**N**", complete **C** and **D** below.

C. The Manager, supervising M.D./furnishing supervisor has informed the M.D./N.P. of required documentation as stated in DMH Guidelines for Use of DMH Parameters # 5. **Y** ☐ **N** ☐

D. The M.D./N.P. has acknowledged the requirement and has agreed to comply with the requirement in the future.
Y ☐ **N** ☐ If **N**, explain on a separate sheet.

26. **Was the client discharged from an inpatient facility within the last 30 days? Y** ☐ **N** ☐

A. If **Y**, enter facility name, discharge date, and reason for admission:

_____

B. If **Y**, enter date and type of first appointment post discharge:

_____

27. **If Substance Use was a factor in the event, was client engaged or were there attempts to engage the client in Co-Occurring Substance Use treatment? Y** ☐ **N** ☐

If **N**, explain:

_____
_____
_____
_____
_____

28. **Identify contributing factors/risk factors and/or stressors:**

_____
_____
_____
_____
_____

29. **List any root cause(s) you identified as relevant to this occurrence:**

_____
_____
_____
_____
_____

30. **List any systems; e.g., protocols/trainings that you have or will institute that may prevent** a **similar event in the future:**

_____
_____
_____
_____
_____

For a Category 3 Event (Suicide), a Category 4 Event (Suicide Attempt Requiring EMT), or Category 7 Event (Suspected/Alleged Homicide by Client), complete Items 31 - 38 on Page 3. Otherwise, there is no need to submit Page 3.

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Complete Page 3 for a Category 3 Event (Suicide), a Category 4 Event (Suicide Attempt Requiring EMT), or Category 7 Event (Suspected/Alleged Homicide by Client).

31. **Describe the method used**:

_____

32. **Was suicide/homicidal behavior risk assessed during the MH treatment episode? Y ☐ N ☐**

A. If **Y**, was a standardized risk assessment tool ever used? **Y ☐ N ☐**

B. If **A** is **Y**, specify the name of standardized risk assessment tool, and attach a copy.

C. If A is **N**, check below which non-standardized method was used:

☐ Non-standard tool (Attach copy)

☐ Other (Specify type of assessment and what questions were asked)

_____

D. If the response to **Item 31** is **Y**, specify the date of the most recent suicide risk assessment:

_____

E. If the response to **Item 31** is **N**, specify the reason:

_____

33. **Was the client determined to be at a significant risk for suicide or a threshold risk for homicide? Y ☐ N ☐**

Note: For definition of a threshold risk, see LACDMH Policy 303.01, Duty to Warn and Protect Third Parties in Response to a Threat

A. If **Y**, describe interventions and follow-up actions, including a plan for safety and dates:

_____

34. **Was a history of previous suicide attempts/aggressive behavior episodes taken? Y ☐ N ☐**

A. If **N**, specify reason: _____

B. If **Y**, was the history positive? **Y ☐ N ☐**

C. If **B** is **Y**, specify date(s), nature of attempt(s) and outcome, including hospitalizations:

_____

35. **If this was** a **suicide or suicide attempt, was** a **history of the suicide(s) of family members taken? Y ☐ N ☐**

A. If **N**, specify reason:

_____

B. If **Y**, was the history positive? **Y ☐ N ☐**

36. **Describe the client's treatment course:**

A. Type(s) of services provided: _____

B. Frequency of services: _____

C. Duration of services: _____

D. What was the date and type of the last service provided prior to the event?

_____

37. **What were the documented goals of treatment and the client's response to each goal?**

_____

_____

38. **Was the client sufficiently engaged in treatment for addressing and managing the documented suicide/homicide risk?**

Y ☐ N ☐

A. Did the client keep appointments? **Y ☐ N ☐**

If **N**, explain, including interventions if any: _____

B. Did the client refuse any treatment recommendations? **Y ☐ N ☐**

If **Y**, specify:_____

C. Were there other signs of lack of engagement? **Y ☐ N ☐**

If **Y**, specify:_____